



WOMEN'S HEALTH QUESTIONNAIRE

Name: _____ DOB: _____ Appointment Date: _____

Primary physician: _____ Referring physician: _____

Describe the reason for today's appointment (your main complaint/problem):

What goals do you hope to accomplish with therapy? _____

When did the problem begin? _____ Is it better, worse, or staying the same? _____

Have you had any prior treatment for this problem? YES NO If yes, please describe? _____

List activities or things that you cannot do because of this problem. How does the problem affect your life?

What are you currently doing to manage the problem? _____

MEDICAL HISTORY (Place a check mark next to any you have had or currently have):

<input type="checkbox"/> Childhood Illnesses	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Serious Injury
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Accident
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Urinary Tract	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Psychiatric Disorder	<input type="checkbox"/> Neurologic Disease
<input type="checkbox"/> Other (please list) _____			

ALLERGIES: Do you have any allergies? YES NO

If yes, please list what you are allergic to and the reaction you have had: _____

MEDICATIONS: Please list all of your present medications (include dosages & frequency taken)

SURGICAL HISTORY: Have you ever had any operations? YES NO

If yes, please list the TYPE of surgery, REASON for surgery, and DATE of surgery

SOCIAL HISTORY:

Occupation: _____ Retired? YES NO
Current marital status: Single__ Married__ Widowed__ Divorced__ Are you sexually active? YES NO
Have you ever smoked tobacco? YES NO If yes, how much? _____
If yes, have you quit? YES NO
Do you drink alcohol? YES NO If yes, how much? _____
Do you use any street drugs? YES NO If yes, what? _____

HEALTH HABITS: (Please answer in space provided)

Do you see a doctor regularly for exams? _____
How many hours do you sleep at night? _____
Do you eat a well-rounded diet? _____
Do you exercise regularly? YES NO If yes, what type of exercise & how often? _____
Do you consider yourself to be healthy? YES NO
Do you have any physical limitations? YES NO If yes, explain: _____

GYNECOLOGIC HISTORY:

Number of pregnancies: _____ Age with first delivery? _____ Age with last delivery? _____
Number of vaginal deliveries: _____ Number of cesarean deliveries: _____
Forceps/Vacuum? YES NO Episiotomy/tears? YES NO Baby's birth weight? _____
Problems during delivery? YES NO If yes, explain: _____
Did you experience incontinence during pregnancy? YES NO
Are your periods regular? YES NO Abnormally painful? YES NO
If painful, how do you cope? _____
Have you gone through menopause? YES NO If yes, at what age? _____
Reason for menopause: Natural? YES NO Due to hysterectomy? YES NO
Do you have a history of yeast infections? YES NO If yes, how often? _____
Have you had any venereal diseases? YES NO If yes, what? _____
Any gynecologic problem(s) not already discussed? YES NO If yes, explain _____

EMOTIONAL HISTORY:

Does emotional stress affect symptoms? YES NO
Have you ever been diagnosed with and/or treated for a nervous condition? YES NO
Have you ever been diagnosed with and/or treated for depression? YES NO
Have you ever experienced domestic violence? YES NO
Have you ever experienced rape? YES NO Date rape? YES NO
Have you ever experienced sexual abuse/molestation? YES NO
Have you ever experienced incest? YES NO

SYMPTOM SEVERITY:

On a scale of 0-10 with 10 being the most severe, what is the current severity of your problem?
0 1 2 3 4 5 6 7 8 9 10

With 0 being not true at all to 10 being true, rate the following statement as it applies to you today:
My problem is controlling my life
0 1 2 3 4 5 6 7 8 9 10

PLEASE COMPLETE THE FOLLOWING SECTIONS THAT ARE APPLICABLE TO YOUR PROBLEM.

FOR ANY PAIN QUESTIONS, PLEASE REFER TO THIS MANKOSKI PAIN SCALE:

- 0 - Pain Free
- 1 - Very minor annoyance with occasional minor twinges. No medication needed.
- 2 - Minor annoyance with occasional strong twinges. No medication needed.
- 3 - Annoying enough to be distracting. Mild painkillers (such as aspirin or ibuprofen) take care of it.
- 4 - Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.
- 5 - Can't be ignored for more than 30 minutes. Mild painkillers make the pain better or more tolerable for 3-4 hours.
- 6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (such as codeine or narcotics) reduce pain for 3-4 hours.
- 7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.
- 8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
- 9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.
- 10 - Unconscious. Pain makes you pass out.

SECTION A: PELVIC PAIN

Do you experience pelvic pain? YES NO (If no, skip to Section B)

If yes, give a description and location of the pain _____

Do you experience pain with intercourse? YES NO

If yes, which of the following cause pain and indicate the severity:

___ Initial penetration - pain rating ____/10

___ Thrusting - pain rating ____/10

___ Orgasm - pain rating ____/10

Does the pain continue after intercourse? YES NO If yes, pain rating ____/10

How long does the pain last? ____ hours or ____ days

Mark any of the following events that cause pain and rate the severity:

___ During pelvic exam - pain rating ____/10

___ Insertion of tampons - pain rating ____/10

___ Sitting - pain rating ____/10

___ Certain clothing - pain rating ____/10

___ Other (describe) _____ - pain rating ____/10

What activities are limited by your pain? _____

What makes the pain worse? _____

What makes the pain better? _____

How long have you had this pelvic pain? _____

Any event (such as accident, surgery, childbirth) associated with the onset of your pelvic pain symptoms? YES NO If yes, explain _____

SECTION B: VOIDING HABITS

Did you have difficulty holding urine as a child? YES NO

As a child, did you wet the bed beyond the age of 5? YES NO

Have you been treated for more than two urinary tract infections this year? YES NO

When was the last time you had a urinary tract infection? _____

Is your urine ever bloody? YES NO

Have you ever been treated with urethral dilatation? YES NO

If yes, how many times? _____ Did it help? YES NO

Do you feel that you urinate too often? YES NO

Do you usually get up to urinate during the sleeping hours? YES NO

If yes, how many times? _____

How many times during the day do you urinate? __ 1-4 __ 5-8 __ 9-12 __ more than 12

How often do you pass urine during the day? Every ____ hours

Is the volume of urine you usually pass __ very small __ small __ average __ large

Do you restrict your fluid intake because of your problem? YES NO

Do you constantly feel an urge to urinate? YES NO

Do you often experience a strong, sudden urge to urinate? YES NO

Do you often feel you must rush to the toilet? YES NO

If yes, does it occur: __ all of the time __ most of the time __ half the time __ some of the time

How long can you hold back the urge to urinate? _____

Do you lose urine when you have the urge to urinate? YES NO

If yes, does it occur: __ all of the time __ most of the time __ half the time __ some of the time

Do you experience a strong sense of urgency with any of the following:

Temperature changes? YES NO Running water? YES NO

Entering the house? YES NO Approaching the toilet? YES NO

Other? YES NO If yes, describe _____

Do you sometimes feel you need to urinate again immediately after urinating? YES NO

Do you void before leaving the house "just in case"? YES NO

Are you conscious of where the nearest toilet is when you are away from home? YES NO

Do you have difficulty emptying your bladder completely? YES NO

If yes, does it occur: __ all of the time __ most of the time __ half the time __ some of the time

How do you manage this problem? _____

Is the urine stream ever hesitant or interrupted? YES NO

If yes, does it occur: __ all of the time __ most of the time __ half the time __ some of the time

Do you need to strain to empty? YES NO

If yes, does it occur: __ all of the time __ most of the time __ half the time __ some of the time

Do you have difficulty telling when your bladder is full? YES NO

Do you dribble just after urinating (such as when you stand up)? YES NO

If yes, does it occur: __ all of the time __ most of the time __ half the time __ some of the time

Do you have trouble stopping your urine midstream? YES NO

SECTION C: URINARY INCONTINENCE

Do you experience uncontrollable loss of urine? YES NO (If no, skip to Section D)

Do you lose urine with any of the following events:

Coughing? YES NO Sneezing? YES NO Lifting objects? YES NO

Straining? YES NO Bending? YES NO Walking? YES NO

During intercourse? YES NO After intercourse? YES NO

Is the volume you lose: __ a few drops __ wet underwear or pad __ soaked pad or clothing

Do you lose urine with a strong urge that cannot be controlled? YES NO

If yes, does it occur __ all of the time __ most of the time __ half the time __ some of the time

SECTION C: URINARY INCONTINENCE (continued)

In which positions does urine loss usually occur?

lying down sitting standing moving from sitting to standing position

Is your loss of urine a continual drip so that you feel constantly wet? YES NO

Do you ever lose urine without any warning or urge? YES NO

If yes, please explain when/how: _____

Do you lose urine without feeling it happen? YES NO

Do you lose urine while you sleep? YES NO

Do you wear protection for urine loss? YES NO

If yes, what type? _____ How many per day? _____

Do you experience hygiene or skin problems related to your leakage? YES NO

SECTION D: BLADDER PAIN

Do you have discomfort associated with your bladder? YES NO (If no, skip to Section E)

If yes, location/description of pain: _____

Mark the events that cause pain and rate the severity:

With bladder fullness - pain rating ____/10

During voiding - pain rating ____/10

After voiding - pain rating ____/10

Other (describe) _____ - pain rating ____/10

What activities are limited by your pain? _____

What makes the pain worse? _____

What makes the pain better? _____

How long have you had this bladder pain? _____

Any event (such as accident, surgery, childbirth) associated with the onset of your bladder pain symptoms? YES NO If yes, explain _____

SECTION E: BOWEL HABITS

How often do you have a bowel movement? _____

Do you ever attempt evacuation without results? YES NO If yes, how often? _____

Do you use any of the following to help you evacuate? (Mark all that apply)

Laxatives (type: _____) Suppository

Enema Manual removal Fiber supplement

Other (describe) _____

What is your typical stool consistency:

Separate hard lumps, like nuts Like a sausage or snake but with cracks on surface

Sausage shaped but lumpy Like a sausage or snake but smooth and soft

Soft blobs with clear cut edges Fluffy pieces with ragged edges or mushy stool

Watery, no solid pieces Combination of all options

Do you ever experience blood in the stool or on the tissue? YES NO

Do you experience a sensation of the need to evacuate? YES NO

If yes, rate the sensation: normal blunted/uncertain strong/urgent

Do you constantly feel an urge to evacuate? YES NO

Do you lose stool with a strong urge that cannot be controlled? YES NO

If yes, does it occur all of the time most of the time half the time some of the time

How long can you hold the urge to evacuate? _____

Do you have a problem with constipation? YES NO

SECTION E: BOWEL HABITS (continued)

Do you strain to pass stool? YES NO

If yes, does it occur ___ all of the time ___ most of the time ___ half the time ___ some of the time

On average, how much time do you spend on the toilet for each evacuation? _____

Do you have difficulty emptying your bowels completely? YES NO

If yes, does it occur ___ all of the time ___ most of the time ___ half the time ___ some of the time

Do you feel stool remains: ___ at the anal opening or ___ higher in the rectum/colon

Do you have difficulty with hygiene after a bowel movement? YES NO

Are you unable to feel the difference between solid stool, liquid stool, and gas? YES NO

SECTION F: BOWEL INCONTINENCE

Are you unable to avoid passing gas in public? YES NO

Do you experience uncontrollable loss of stool or stool seepage? YES NO (If no, skip to Section G)

Do you lose stool with any of the following events?

Coughing? YES NO Sneezing? YES NO Lifting? YES NO

Straining? YES NO Releasing gas? YES NO Urinating? YES NO

Aerobic exercise? YES NO Intercourse? YES NO

Is the amount you lose:

___ Stain/smear ___ 2 Tbsp or less ___ ¼ to ½ cup ___ ½ to 1 cup ___ greater than 1 cup

What is the consistency of the stool you lose?

___ formed/solid ___ hard balls ___ loose/unformed ___ liquid/mucous

How often does this happen? _____

Do you lose stool with a strong urge that cannot be controlled? YES NO

If yes, does it occur ___ all of the time ___ most of the time ___ half the time ___ some of the time

Do you ever lose stool without any warning or urge? YES NO

If yes, explain when and how? _____

Do you lose stool without feeling it happen? YES NO

If yes, explain when and how? _____

Does the stool loss, seepage or staining occur after a bowel movement? YES NO

Does the stool loss, seepage or staining occur during sleep? YES NO

Do you wear protection for stool loss? YES NO

If yes, what type? _____ How many per day? _____

SECTION G: BOWEL/ABDOMINAL PAIN

Do you experience pain related to bowel function? YES NO (If no, you have completed this form!)

If yes, location/description of pain _____

Mark the following events that cause pain and rate the severity:

___ Before bowel movement - pain rating ____/10

___ During bowel movement - pain rating ____/10

___ After bowel movement - pain rating ____/10

___ With meals - pain rating ____/10

___ Other (describe) _____ - pain rating ____/10

What activities are limited by your pain? _____

What makes the pain worse? _____

What makes the pain better? _____

How long have you had this bowel/abdominal pain? _____

Any event (such as accident, surgery, childbirth) associated with the onset of your bowel/abdominal pain symptoms? YES NO If yes, explain _____
